Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ROSHAN L SHARMA MD PA
520 TEXAS BLVD
TEXARKANA TX 75501

Respondent Name
TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative
Box Number 54

MFDR Tracking Number
M4-13-1775-01

MFDR Date Received
March 11, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor did not submit a position summary with the DWC060 request.

Amount in Dispute: $340.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor billed CPT code 99215 for date 8/28/12. Texas Mutual applied the 1995/1997 E/M documentation guidelines to the documentation of 8/28/12. The result is a history that is problem focused, an exam that is expanded problem focused, and decision making that is moderate in complexity. The requestor also billed CPT code 99214 for date 8/29/12. Texas Mutual applied the 1995/1997 E/M documentation guidelines to the documentation of 8/29/12. The result is a history that is expanded problem focused, an exam that is expanded problem focused, and decision making that is moderate in complexity."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 28, 2012	99215	$195.00	$195.00
August 29, 2012	99214	$145.00	$0.00
TOTAL		$340.00	$195.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - CAC-150 – Payer deems the information submitted does not support this level of service
   - 890 – Denied per AMA CPT code description for level of service and/or nature of presenting problems
   - CAC-16 – Claim/service lacks information which is needed for adjudication
   - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
   - 225 – the submitted documentation does not support the service being billed, we will re-evaluated this upon receipt of clarifying information
   - 891 – No additional payment after reconsideration
   - 878 – Appeal (request for reconsideration) previously processed, refer to rule 133.250 (H)
   - CAC-18– Duplicate claim/service
   - 890 – Denied per AMA CPT Code description for level of service and/or nature of presenting problems.

Issues

1. Did the requestor submit documentation to support the billing of CPT codes 99214 and 99215?
2. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code § 134.203 “(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   The requestor seeks reimbursement for CPT code 99215 rendered on August 28, 2012. The CPT code 99215 is defined by the AMA CPT Code book as follows; “Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.” The requestor submitted sufficient documentation to support the billing of CPT code 99215, as a result, reimbursement is determined pursuant to 28 Texas Administrative Code § 134.203 (c).

   The requestor seeks reimbursement for CPT code 99214 rendered on August 29, 2012. The CPT code 99214 is defined by the AMA CPT Code book as follows; “Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.” The requestor submitted insufficient documentation to support the billing of CPT code level 99214, as a result, reimbursement for CPT code 99214 cannot be recommended.
2. Per 28 Texas Administrative Code § 134.203 “(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year."

   Per 28 Texas Administrative Code § 134.203 “(h) When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the least of the: (1) MAR amount; (2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount; or (3) fair and reasonable amount consistent with the standards of §134.1 of this title.”

   The MAR amount for CPT code 99215 is $215.02, the requestor seeks reimbursement in the amount of $195.00, therefore this amount is recommended.

   Review of the submitted documentation finds that the requestor is entitled to reimbursement in the amount of $195.00 for CPT code 99215 rendered on August 28, 2012.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $195.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $195.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	November 7, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.